SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Filing at a Glance

Company: AMEX Assurance Company

Product Name: Identity Protection/Business Identity Protection	SERFF Tr Num: AMEE-125527044	State: Arkansas
TOI: 09.0 Inland Marine	SERFF Status: Closed	State Tr Num: EFT $50
Sub-TOI: 09.0006 Other Personal Inland Marine	Co Tr Num: AX825-AR-0001F	State Status: Fees verified and received
Filing Type: Form	Co Status:	Reviewer(s): Becky Harrington, Betty Montesi, Brittany Yielding
	Author: Michelle Correa	Disposition Date: 03/26/2008
	Date Submitted: 03/17/2008	Disposition Status: Approved
Effective Date Requested (New): On Approval		Effective Date (New):
Effective Date Requested (Renewal): On Approval		Effective Date (Renewal):

State Filing Description:

General Information

Project Name: IDP/BIDP	Status of Filing in Domicile: Pending
Project Number: AX825-AR-0001F	Domicile Status Comments:
Reference Organization:	Reference Number:
Reference Title:	Advisory Org. Circular:
Filing Status Changed: 03/26/2008	
State Status Changed: 03/17/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

March 17, 2008

Arkansas Department of Insurance

Via SERFF

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

RE: FILING SUBMITTED FOR APPROVAL

AMEX Assurance Company

Group Inland Marine Filing – "Identity Protection" and "Business Identity Protection"

Company FEIN: 36-2760101

NAIC #: 27928

Company File Number: AX825-AR-0001

FORMS:

IDP-DOC 03/08 Description of Coverage

IDP-EN 03/08 Enrollment Request Form

IDP-EN-IND 03/08 Enrollment Request Form

IDP-EN-MULTI 03/08 Enrollment Request Form-Multi

BIDP-DOC 03/08 Description of Coverage

BIDP-EN 03/08 Enrollment Request Form

BIDP-EN-IND 03/08 Enrollment Request Form

BIDP-EN-MULTI 03/08 Enrollment Request Form-Multi

On behalf of AMEX Assurance Company, I am respectfully submitting the above-referenced forms for your review and approval pursuant to 23-79-109(a)(2) of the Arkansas Insurance Code. These forms are new and are not currently being used in your state.

These forms will be used under Master Group Policy AX825. This Policy was sitused and approved in the state of Rhode Island on March 11, 2003. This is a Group Inland Marine Policy. The Group Policyholder, the AMEX Assurance Group Identity Protection Insurance Trust, consists of members of participating organizations interested in identity theft insurance. This program will be marketed to members of participating organizations interested in identity fraud protection, and only individual members may enroll for coverage. These members are ultimately responsible for the premium and do receive the benefits under the program.

This plan, "Identity Protection" provides coverage for incurred expenses due to Identity Theft or Identity Fraud. These

expenses include, but are not limited to, costs for obtaining credit reports, re-filing applications, lost wages, legal fees, fraudulent transactions, and other administrative fees. There is a monthly and annual billing plan.

This plan, “Business Identity Protection” provides coverage for incurred expenses due to Identity Theft or Identity Fraud. These are for personal and/or business expenses that include, but are not limited to, costs for obtaining credit reports, re-filing applications, lost wages, legal fees, fraudulent transactions, communication costs, and other administrative fees. There is a monthly and annual billing plan.

Bracketed material throughout the forms is variable. Bracketed information may be included or omitted, depending on what will be marketed. Company logos and Plan names will change depending the product name and Plan being marketed.

This filing has been reviewed and to the best of my knowledge, complies with all applicable Arkansas laws and regulations now in effect.

If you should have any questions, please contact me by phone at 1-920-431-4065, by fax at 1-920-431-4040 or by email at Kiley.M.Rickert@aexp.com.

Sincerely,

Kiley Rickert

Kiley Rickert
Senior Compliance Analyst
AMEX Assurance Company

Company and Contact

Filing Contact Information

Kiley Rickert, Sr. Compliance Analyst kiley.m.rickert@aexp.com

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

480 Pilgrim Way
Green Bay, WI 54304

(800) 618-8441 [Phone]
(920) 431-4040[FAX]

Filing Company Information

AMEX Assurance Company
480 Pilgrim Way
Ste 1400
Green Bay, WI 54304
(920) 431-4000 ext. [Phone]

CoCode: 27928
Group Code: 4

Group Name:
FEIN Number: 36-2760101

State of Domicile: Illinois
Company Type:

State ID Number:

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
AMEX Assurance Company	$50.00	03/17/2008	18703026

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Becky Harrington	03/26/2008	03/26/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Becky Harrington	03/17/2008	03/17/2008	Michelle Correa	03/25/2008	03/25/2008

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Disposition

Disposition Date: 03/26/2008
Effective Date (New):
Effective Date (Renewal):
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	Response Letter	Approved	Yes
Form	Description of Coverage	Approved	Yes
Form	Enrollment Request Form	Approved	Yes
Form *(revised)*	Enrollment Request Form	Approved	Yes
Form	Enrollment Request Form		Yes
Form	Enrollment Request Form-Multi	Approved	Yes
Form	Description of Coverage	Approved	Yes
Form	Enrollment Request Form	Approved	Yes
Form *(revised)*	Enrollment Request Form	Approved	Yes
Form	Enrollment Request Form		Yes
Form	Enrollment Request Form-Multi	Approved	Yes

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/17/2008
Submitted Date	03/17/2008
Respond By Date	

Dear Kiley Rickert,

This will acknowledge receipt of the captioned filing.

Objection 1

- Enrollment Request Form (Form)
- Enrollment Request Form-Multi (Form)

Comment: Please explain the difference in these two forms.

Objection 2

- Enrollment Request Form (Form)
- Enrollment Request Form-Multi (Form)

Comment: Please explain the difference in these two forms.

Please feel free to contact me if you have questions.
Sincerely,
Becky Harrington

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/25/2008
Submitted Date	03/25/2008

Dear Becky Harrington,

Comments:

Response 1

Comments: Please see response to the objection dated 3/17/2008

Related Objection 1

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Applies To:

- Enrollment Request Form (Form)
- Enrollment Request Form-Multi (Form)

Comment:

Please explain the difference in these two forms.

Related Objection 2

Applies To:

- Enrollment Request Form (Form)
- Enrollment Request Form-Multi (Form)

Comment:

Please explain the difference in these two forms.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Response Letter

Comment: Please see below.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Enrollment Request Form	IDP-EN-IND 03/08		Application/Binder/Enrollment	Withdrawn		0	
Previous Version							
Enrollment Request Form	*IDP-EN-IND 03/08*		*Application/Binder/Enrollment*	*New*		*0*	IDP Enrollment Form. IND 3.6.08.pdf
Enrollment Request Form	BIDP-EN-IND 03/08		Application/Binder/Enrollment	Withdrawn		0	
Previous Version							
Enrollment Request Form	*BIDP-EN-IND 03/08*		*Application/Binder/Enrollment*	*New*		*0*	BIDP Enrollment

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Form IND
3.6.08.pdf

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

No Rate/Rule Schedule items changed.

Sincerely,
Michelle Correa

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type	Action	Action Specific Data	Readability	Attachment
Approved	Description of Coverage	IDP-DOC 03/08		Certificate	New		0.00	IDP DOC 3.6.08.pdf
Approved	Enrollment Request Form	IDP-EN 03/08		Application/ Binder/Enrollment	New		0.00	IDP Enrollment Form. Group 3.6.08.pdf
Approved	Enrollment Request Form	IDP-EN-IND 03/08		Application/ Binder/Enrollment	Withdrawn	Replaced Form #: Previous Filing #:	0.00	
Approved	Enrollment Request Form-Multi	IDP-EN-MULTI 03/08		Application/ Binder/Enrollment	New		0.00	Combined IDP Enrollment Form.3.6.08.pdf
Approved	Description of Coverage	BIDP-DOC 03/08		Certificate	New		0.00	BIDP DOC 3.6.08.pdf
Approved	Enrollment Request Form	BIDP-EN 03/08		Application/ Binder/Enrollment	New		0.00	BIDP Enrollment Form Group 3.6.08.pdf
Approved	Enrollment Request Form	BIDP-EN-IND 03/08		Application/ Binder/Enrollment	Withdrawn	Replaced Form #: Previous Filing #:	0.00	
Approved	Enrollment Request Form-Multi	BIDP-EN-MULTI 03/08		Application/ Binder/Enrollment	New		0.00	Combined BIDP Enrollment Form 3.6.08.pdf

IDENTITY PROTECTION
DESCRIPTION OF COVERAGE

Underwritten by AMEX Assurance Company
Administrative Office, [480 Pilgrim Way, Suite 1400, Green Bay, WI 54304]

Covered Person: [John Q. Public]
Certificate Number: [XXXXXXXXX]
Coverage Effective Date: [XX/XX/XXXX]
Coverage Limit: [$XX, XXX]
Billing Plan: [Monthly] [Annual]
Premium: [$XX.XX]
Your Participating Organization: [ABC Company]

If You are not fully satisfied with the coverage described within, You may void it by returning this Description of Coverage document to Us within 30 days after receipt and Your premium will be refunded. Any termination request after 30 days will receive a pro rata refund. After doing so, this Description of Coverage will be void from the Coverage Effective Date. This Description of Coverage must be returned to: AMEX Assurance Company, Attn: [Identity Protection, PO BOX 19020 Green Bay, WI 54307-9020]. This 30 day period is only applicable to the initial Description of Coverage received when first enrolled in the Plan and does not apply to any subsequent receipts of a Description of Coverage or reenrollment.

IMPORTANT INFORMATION FOR YOU

This Description of Coverage replaces any other Description of Coverage that You may have previously received. The benefits described in this document are subject to all the terms, conditions, and exclusions of the Policy. **This Description of Coverage is an important document. Please read it and keep it in a safe place.**

DEFINITIONS

Certain words used in this Description of Coverage are capitalized throughout and have special meanings. Wherever used herein, the singular shall include the plural, the plural shall include the singular, as the context requires.

Account means Your credit, charge or debit card issued in Your name to which premiums will be billed.

Company means AMEX Assurance Company, and its duly authorized agents.

Coverage Effective Date means 12:01 a.m. Central Time on the date Your enrollment is received, approved and validated by Us. Approval requires payment of the first premium.

Coverage Period means the time period beginning on Your Coverage Effective Date and ending when Your enrollment is terminated or cancelled.

Covered Person means a person:
1. who has properly enrolled in the Plan;
2. who has paid the premium;
3. who is currently a member of a Participating Organization; and
4. whose Permanent Residence is in the 50 United States of America or the District of Columbia.

Identity Fraud means an Occurrence involving the knowing transfer or use, without lawful authority, of a means of identifying You and committing an act that violates federal law or constitutes a felony or misdemeanor under applicable state or local law.

Identity Theft means the Occurrence of a misappropriation of the personal identity information of You, including without limitation, social security number, account numbers, passwords, credit card numbers, addresses, or phone numbers, which results in, or could reasonably result in, the wrongful and fraudulent use of such information.

Master Policyholder means Bank of Newport as Trustee for AMEX Assurance Group Identity Protection Insurance Trust.

Occurrence means a single act or series of acts, the first of which must occur during Your Coverage Period, dating from the sole or initial act in a series of acts, committed by the same person or persons, which creates eligibility for payment of a Plan benefit. The Occurrence shall be deemed one Occurrence if it is attributable directly or indirectly to one act or to one series of similar acts.

Participating Organization means the organization, of which You are a member that has completed a Participating Organization Application under the Master Policy and has been accepted by the Company.

Permanent Residence means the one primary dwelling place where You reside.

Plan means the Policy and the benefits described therein.

Policy means the Group Insurance Master Policy (AX825 issued to the Master Policyholder.)

We, Us, Our means the Company.

You, Your means the Covered Person.

DESCRIPTION OF BENEFITS

We will reimburse for the following expenses incurred by You, up to [$15,000] per Occurrence, provided the Occurrence was during Your Coverage Period, as a direct result of Identity Fraud and/or Identity Theft:

1. costs for obtaining a maximum of four (4) credit reports from an organization approved by Us, subsequent to an Occurrence;
2. costs for refiling applications for loans, grants and other credit or debt instruments that are rejected solely because the lender received incorrect information from any source;
3. costs for Your time away from work as a result of Your efforts to amend or rectify records as to Your identity. Our payments are based on Your lost wages, which includes partial or whole days;
4. costs for reasonable accountant, attorney, and related court fees;
5. costs incurred for which You are held liable with respect to fraudulent transactions involving any of Your credit, charge or debit cards or card information;
6. costs incurred for which You are held liable with respect to any new accounts opened involving the fraudulent use of Your name or identity information;
7. costs for fees incurred by a financial institution or credit issuer;
8. costs for deductibles payable by You from other personal identity theft insurance policies that provide coverage for expenses not covered under this Plan;
9. costs for obtaining day care or elder care necessitated by an Occurrence; and
10. costs to report an Identity Theft or Identity Fraud to law enforcement agencies, financial institutions, credit grantors, credit agencies, merchants, and vendors or to amend or rectify records or to replace identifying materials, to include the following:
    a. notarizing affidavits or similar documents;
    b. long distance phone calls;
    c. postage;
    d. copying documents;
    e. stolen driver's license;
    f. stolen checks;
    g. stolen passport; and
    h. stolen Permanent Alien Resident Card.

Maximum Limit Per Covered Person

Duplicate or multiple enrollments by any one individual Covered Person shall not obligate the Company to pay in excess of the limit stated herein for expenses incurred as a result of an Occurrence of Identity Fraud and/or Identity Theft covered under this Plan. Upon discovery of the duplicate or multiple enrollments, the Company will consider You to be insured under the Description of Coverage that provides You with the greatest amount of coverage. We will refund any duplicate premium payments. The records maintained by the Company shall determine the insurance provided to You under this Plan.

ELIGIBILITY AND ENROLLMENT

You will be fully insured for this coverage when You have properly enrolled and have paid all premiums when due.

PREMIUMS

We will provide insurance coverage in return for premium payment. Premiums are payable by You in a manner acceptable to Us. Your initial premium is due on Your Coverage Effective Date and will automatically be billed [monthly] [annually] to Your enrolled [American Express] Card Account thereafter. Premiums must be paid to Us on or before the due date.

Premium Changes

We have the right to change the premium rates. We will provide written notice to You at least [thirty (30)] days before the date of change. The premium may also change any time the terms of the Plan are changed.

Premium Credits/Refunds

The premium for shorter periods of coverage (including those due to termination of the Account or cancellation of the Policy) is the pro rata portion of the premium which is unearned and credited to Your enrolled [American Express] Card Account. A pro rata refund of premium will occur when You notify Us of Your active military duty.

Coverage Amount	Premium
[$15,000]	[$5.95 Per Month]
	[$59.95 Per Year]

EXCLUSIONS

Benefits are not payable if the Occurrence for which coverage is sought was directly or indirectly, wholly or partially, contributed to or caused by:

1. war or act of war, including undeclared or civil war;
2. any activity directly related to and occurring while in the service of any armed military force of any nation state recognized by the United Nations;
3. any fraudulent, dishonest, or criminal act by You or anyone acting in concert with You, including Your authorized representative, whether acting alone or in collusion with others;
4. entrustment;
5. Your business pursuits; or
6. bodily injury.

[For residents of Washington, the first paragraph of this section is removed and replaced with the following: We will not pay for an Occurrence caused by any of the excluded events described below. An Occurrence will be considered to have been caused by an excluded event if the Occurrence of that event directly and solely results in the Occurrence, or initiates a sequence of events that result in an Occurrence, regardless of the nature of any intermediate or final event in that sequence.]

CLAIM PROVISIONS

If You experience an Occurrence for which You believe a benefit is payable under this Plan, You must provide both Notice of Claim and Proof of Loss.

Notice of Claim

Notice of Claim should be provided to Us within [thirty (30)] days of the Occurrence. You may contact Us by calling toll-free stateside [1-800-671-9285]. You may also write to Us at AMEX Assurance Company, Attn: [Identity Protection, PO BOX 19020, Green Bay, WI 54307-9020].

Failure to provide Notice of Claim within [thirty (30)] days will not invalidate a claim or reduce any benefit payment that may be found to be eligible, if it can be shown that it was provided as soon as reasonably possible. No claim will be denied based upon Your failure to provide notice within such specified time, unless this failure operates to prejudice the right of the Company.

Claim Forms

At the time You provide Us with Notice of Claim, We will assist You with Your Proof of Loss by providing You with instructions and/or forms, which You may have to complete and return to Us. If we do not send the forms within fifteen (15) days after We receive Notice of Claim, You may meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the Occurrence in accordance with the Proof of Loss provision. You are required to cooperate with Us and provide forms and/or documentation as requested by Us which is required and necessary to process Your claim and determine if benefits are payable.

Proof of Loss

Proof of Loss requires You to send Us all the information We request, at Your expense, in order that Your claim may be evaluated and that We may make a determination as to whether the claim may be paid. You must provide Us with satisfactory Proof of Loss within [ninety (90) days] or as soon as reasonably possible, after the date of the Occurrence. Your Proof of Loss documentation may be mailed to Us at the same address provided for mailing Your Notice of Claim. We reserve the right to request all the information We deem necessary to determine that Your claim is payable, and We will not consider that We have received complete Proof of Loss until the information We have requested is received.

Proof of Loss may require documentation consisting of, but not necessarily limited to, the following:

1. a completed claim form;
2. a Police Report or Federal Trade Commission Report;
3. detailed receipts, bills or other records supporting Your claim for covered expenses;
4. a report of a financial institution with respect to fraudulent withdrawals or purchases;
5. the insurance terms for Your other sources of insurance; and
6. written confirmation from the financial institution or credit issuer that they determined the transaction is fraudulent and that no payment was made to You for the Occurrence.

It is Your responsibility to provide all required documentation We request.

Payment of Claim
A claim for benefits provided by this Plan will be paid upon Our receipt and review of Your complete Proof of Loss documentation and Our determination that a claim is payable according to the terms of the Plan.

Any payment made by Us in good faith pursuant to this or any other provision of this Plan will fully discharge Us to the extent of such payment.

TERMINATION OR CANCELLATION

You may terminate Your enrollment at any time by giving Us written or verbal notice in advance of such termination. Notice of termination may be sent to AMEX Assurance Company, Attn: [Identity Protection, PO BOX 19020, Green Bay, WI 54307-9020], or by calling [1-800-671-9285]. The effective date of termination will be the date We receive and validate such notice, or a later date as You advise.

Coverage will cease on the earliest of the following:

1. the date We determine You, or anyone acting on Your behalf, committed fraud or intentionally misrepresented information in enrollment or presentation of a claim;
2. the date the Policy or any benefit under the Policy is cancelled. We will provide at least sixty (60) days [for residents of Kentucky seventy-five (75) days] advance written notice to You at Your last known address. The notice will include the reason for cancellation;
3. the date You are no longer a member of a Participating Organization;
4. the date the Participating Organization in which You are a member ceases to participate in the Policy;
5. the date the Plan is not available in the location where You maintain a Permanent Residence;
6. the date You move Your Permanent Residence to a state where the Plan is not available;
7. the date You request termination of insurance; or
8. the date We are unable to bill Your premiums due to the status of Your Account. Coverage will continue through the Coverage Period for which premiums have been paid in full.

Cancellation or Termination of this Policy by You or the Company will not prejudice any claim originating prior to that date, subject to all other terms of this Policy.

GENERAL PROVISIONS

Change of Permanent Residence
If the change is to a different state, Your Policy provisions and rates may be adjusted to conform to the requirements of that state. Notification of any such Policy change will be included in the new documents issued to You.

Clerical Error
A clerical error made by the Company will not invalidate insurance otherwise validly in force nor continue insurance not validly in force.

Conformity with State and Federal Law
If a Plan provision does not conform to applicable provisions of State or Federal law, the Plan is hereby amended to comply with such law.

Entire Contract; Representation; Change
This Description of Coverage, the Policy and any application, endorsements or riders make up the entire contract. Any statement You make is a representation and not a warranty. This Description of Coverage may be changed at any time by written agreement between the Master Policyholder and the Company. Only the President, Vice-President or Secretary of the Company may change or waive the provisions of the Description of Coverage. No agent or other person may change the Description of Coverage or waive any of its terms. This Description of Coverage may be changed at any time by providing notice to You. A copy of the Policy will be maintained and kept by the Master Policyholder and may be examined at any time.

Fraud
If any request for benefits made under the Plan is determined to be fraudulent, or if any fraudulent means or devices are used by You or by anyone acting on Your behalf to obtain benefits, all benefits will be denied.

We do not provide coverage to a Covered Person who, whether before or after an Occurrence, has:

1. concealed or misrepresented any fact upon which we rely, if the concealment or misrepresentation is material and is made with the intent to deceive; or
2. concealed or misrepresented any fact if the fact misrepresented contributes to the Occurrence.

Legal Actions
No legal action may be brought to recover against this Plan until [sixty (60)] days after Proof of Loss has been received by Us. No such action may be brought after [three (3)] years (for residents of Arkansas five (5) years, residents of South Dakota six (6) years, and residents of Missouri ten (10) years) from the time written Proof of Loss is required to be given.

[For residents of Alaska, the Legal Actions section is revised to include: If there are any claims, the three (3) year timeframe does not begin to run until after the claim has been denied.]

Right of Recovery
If We make a payment to You under this Plan and You recover an amount from another, equal to or less than Our payment, You shall hold in trust for Us the proceeds of the recovery and reimburse Us to the extent of Our payment. If Our payments exceed the maximum amount payable under the benefits of this Plan, We have the right to recover from You any amount exceeding the maximum amount payable.

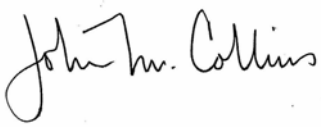
Subrogation
In the event of any payment under this Policy, We shall be subrogated to the extent of such payment to all Your rights of recovery. You shall execute all papers required and shall do everything necessary to secure and preserve such rights, including the execution of such documents necessary to enable Us to effectively bring suit or otherwise pursue subrogation rights in Your name. You shall do nothing to prejudice such subrogation rights. We shall be entitled to a recovery as stated in these provisions only after You have been fully compensated for damages by another party.

For residents of Louisiana, the Right of Recovery and Subrogation sections are revised to reflect: If the Company makes any payment under this Policy and the Covered Person has the right to recover damages from another, the Company shall be subrogated to that right. However, the Company's right to recover is subordinate to the Covered Person's right to be fully compensated.]

IN WITNESS WHEREOF, We have caused this Description of Coverage to be signed by Our officers:

[

[Joy A. Hanson]
President
AMEX Assurance Company



]

[John M. Collins]
Secretary
AMEX Assurance Company

Identity Protection

Enrollment Request for the Exclusive Use of:

Yes, Please Enroll Me in *Identity Protection* Under the following billing plan:
(select one of the following billing plans)

☐ Monthly Plan at $5.95 per month ☐ Annual Plan at $59.95 per year

I request enrollment in *Identity Protection*, underwritten by AMEX Assurance Company, under Master Policy AX825. I understand and agree that if I return this form signed and have not checked one of the billing plans, I will be enrolled in the Monthly Plan.

I have read, understand and agree to the Summary Terms and Conditions of the Policy AX825 explained in this enrollment packet. I understand that coverage is effective when AMEX Assurance Company receives, approves and validates this enrollment request and the first premium is paid. I understand that the premium will be billed to my Account monthly or annually until I notify AMEX Assurance Company to terminate my enrollment.

Please bill my monthly or annual premium to the following American Express Account:

Card number _____ Expiration _____/_____

X_____ _____/_____/_____
Signature of Enrollee (Please sign in ink) Today's Date

(_____)_____
Telephone Number (required)

Any person who knowingly and with intent to defraud any insurance company, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

Identity Protection

Enrollment Request for the Exclusive Use of:

Yes, Please Enroll Me in *Identity Protection* under the following billing plan:
(select one of the following billing plans)

☐ Monthly Plan at $5.95 per month ☐ Annual Plan at $59.95 per year

I request enrollment in *Identity Protection*, underwritten by AMEX Assurance Company. I understand and agree that if I return this form signed and have not checked one of the billing plans, I will be enrolled in the Monthly Plan.

I have read, understand and agree to the Summary Terms and Conditions of the Policy explained in this enrollment packet. I understand that coverage is effective when AMEX Assurance Company receives, approves and validates this enrollment request and the first premium is paid. I understand that the premium will be billed to my Account monthly or annually until I notify AMEX Assurance Company to terminate my enrollment.

Please bill my monthly or annual premium to the following American Express Account:

Card number _____ Expiration _____/_____

X_____ _____/_____/_____
Signature of Enrollee (Please sign in ink) Today's Date

(_____)_____
Telephone Number (required)

Any person who knowingly and with intent to defraud any insurance company, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

BUSINESS IDENTITY PROTECTION
DESCRIPTION OF COVERAGE

Underwritten by AMEX Assurance Company
Administrative Office, [480 Pilgrim Way, Suite 1400, Green Bay, WI 54304]

Covered Person: [John Q. Public]
Business Name: [ABC Company]
Coverage Effective Date: [XX/XX/XXXX]
Premium: [$XXX.XX]
Your Participating Organization: [ABC Company]

Certificate Number: [XXXXXXXXX]
Coverage Limit: [$XX, XXX]
Billing Plan: [Monthly] [Annual]

If You are not fully satisfied with the coverage described within, You may void it by returning this Description of Coverage document to Us within 30 days after receipt and Your premium will be refunded. Any termination request after 30 days will receive a pro rata refund. After doing so, this Description of Coverage will be void from the Coverage Effective Date. This Description of Coverage must be returned to: AMEX Assurance Company, Attn: [Business Identity Protection, PO BOX 19020 Green Bay, WI 54307-9020]. This 30 day period is only applicable to the initial Description of Coverage received when first enrolled in the Plan and does not apply to any subsequent receipts of a Description of Coverage or reenrollment.

IMPORTANT INFORMATION FOR YOU

This Description of Coverage replaces any other Description of Coverage that You may have previously received. The benefits described in this document are subject to all the terms, conditions, and exclusions of the Policy. **This Description of Coverage is an important document. Please read it and keep it in a safe place.**

DEFINITIONS

Certain words used in this Description of Coverage are capitalized throughout and have special meanings. Wherever used herein, the singular shall include the plural, the plural shall include the singular, as the context requires.

Account means Your credit, charge or debit card issued in Your name to which premiums will be billed.

Company means AMEX Assurance Company, and its duly authorized agents.

Coverage Effective Date means 12:01 a.m. Central Time on the date Your enrollment is received, approved and validated by Us. Approval requires payment of the first premium.

Coverage Period means the time period beginning on Your Coverage Effective Date and ending when Your enrollment is terminated or cancelled.

Covered Person means a person:
1. who has properly enrolled in the Plan and paid the premium;
2. who owns a small business;
3. who is currently a member of a Participating Organization; and
4. whose Permanent Residence is in the 50 United States of America or the District of Columbia.

Identity Fraud means an Occurrence involving the knowing transfer or use, without lawful authority, of a means of identifying You and committing an act that violates federal law or constitutes a felony or misdemeanor under applicable state or local law.

Identity Theft means the Occurrence of a misappropriation of the personal identity information of You or Your small business, including, without limitation, social security numbers, account numbers, passwords, credit card numbers, addresses, or phone numbers, which results in, or could reasonably result in, the wrongful and fraudulent use of such information.

Master Policyholder means Bank of Newport as Trustee for AMEX Assurance Group Identity Protection Insurance Trust.

Occurrence means a single act or series of acts, the first of which must occur during Your Coverage Period, dating from the sole or initial act in a series of acts, committed by the same person or persons, which creates eligibility for payment of a Plan benefit. The Occurrence shall be deemed one Occurrence if it is attributable directly or indirectly to one act or to one series of similar acts.

Participating Organization means the organization, of which You are a member, which has completed a Participating Organization Application under the Master Policy and has been accepted by the Company.

Permanent Residence means the one primary dwelling place where You reside.

Plan means the Policy and the benefits described therein.

Policy means the Group Insurance Master Policy (AX825 issued to the Master Policyholder).

We, Us, Our means the Company.

You, Your means the Covered Person.

DESCRIPTION OF BENEFITS

We will reimburse for the following expenses incurred by You, up to [$20,000] [$30,000] per Occurrence, provided the Occurrence was during Your Coverage Period, as a direct result of Identity Fraud and/or Identity Theft:

1. costs for obtaining a maximum of four (4) credit reports from an organization approved by Us, subsequent to an Occurrence;
2. costs for refiling applications for personal or business loans, grants and other credit or debt instruments that are rejected solely because the lender received incorrect information from any source;
3. costs for Your time away from work as a result of Your efforts to amend or rectify records as to Your identity. Our payments are based on Your lost wages, which includes partial or whole days;
4. costs for reasonable accountant, attorney, and related court fees;
5. costs incurred for which You are held liable with respect to fraudulent transactions involving any of Your personal or small business credit, charge, or debit cards or card information;
6. costs incurred for which You are held liable with respect to any new accounts opened involving the fraudulent use of Your personal or small business name or identity information;
7. costs for fees incurred by a financial institution or credit issuer;
8. costs for public relations by legal or other professionals approved by Us;
9. costs for deductibles payable by You from other personal or business identity theft insurance policies that provide coverage for expenses not covered under this Plan;
10. costs for obtaining day care or elder care necessitated by an Occurrence;
11. costs to communicate to partners, customers, vendors, employees, or suppliers; and
12. costs to report to law enforcement agencies, financial institutions, credit grantors, credit agencies, merchants, and vendors or to amend or rectify records or to replace identifying materials, to include the following:
    a. notarizing affidavits or similar documents;
    b. long distance phone calls;
    c. postage;
    d. copying documents;
    e. stolen driver's license;
    f. stolen personal or business checks;
    g. stolen passport; and
    h. stolen Permanent Alien Resident Card.

Maximum Limit Per Covered Person

Duplicate or multiple enrollments by any one individual Covered Person shall not obligate the Company to pay in excess of the limit stated herein for expenses incurred as a result of an Occurrence of Identity Fraud and/or Identity Theft covered under this Plan. Upon discovery of the duplicate or multiple enrollments, the Company will consider You to be insured under the Description of Coverage that provides You with the greatest amount of coverage. We will refund any duplicate premium payments. The records maintained by the Company shall determine the insurance provided to You under this Plan.

ELIGIBILITY AND ENROLLMENT

You will be fully insured for this coverage when You have properly enrolled, paid the premium at enrollment, and paid all premiums when due.

PREMIUMS

We will provide insurance coverage in return for premium payment. Premiums are payable by You in a manner acceptable to Us. Your initial premium is due on Your Coverage Effective Date and will automatically be billed [monthly] [annually] to Your enrolled [American Express] Card Account thereafter. Premiums must be paid to Us on or before the due date.

Premium Changes

We have the right to change the premium rates. We will provide written notice to You at least [thirty (30)] days before the date of change. The premium may also change any time the terms of the Plan are changed.

Premium Credits/Refunds
The premium for shorter periods of coverage (including those due to termination of the Account or cancellation of the Policy) is the pro rata portion of the premium which is unearned and credited to Your enrolled [American Express] Card Account. A pro rata refund of premium will occur when You notify Us of Your active military duty.

Coverage Amount	Premium
[$20,000]	[$10.99 per Month]
	[$126.00 per Year]
[$30,000]	[$12.99 per Month]
	[$144.00 per Year]

EXCLUSIONS

Benefits are not payable if the Occurrence for which coverage is sought was directly or indirectly, wholly or partially, contributed to or caused by:

1. war or act of war, including undeclared or civil war;
2. any activity directly related to and occurring while in the service of any armed military force of any nation state recognized by the United Nations;
3. any fraudulent, dishonest, or criminal act by You or anyone acting in concert with You, including Your authorized representative or Your employee, whether acting alone or in collusion with others;
4. entrustment; or
5. bodily injury.

[For residents of Washington, the first paragraph of this section is removed and replaced with the following: We will not pay for loss caused by any of the excluded events described below. Loss will be considered to have been caused by an excluded event if the Occurrence of that event directly and solely results in loss, or initiates a sequence of events that result in loss, regardless of the nature of any intermediate or final event in that sequence.]

CLAIMS PROVISIONS

If You experience an Occurrence for which You believe a benefit is payable under this Plan, You must provide both Notice of Claim and Proof of Loss.

Notice of Claim
Notice of Claim should be provided to Us within [thirty (30)] days of the Occurrence. You may contact Us by calling toll-free stateside [1-800-671-9285]. You may also write to Us at AMEX Assurance Company, Attn: [Business Identity Protection, PO BOX 19020, Green Bay, WI 54307-9020].

Failure to provide Notice of Claim within [thirty (30)] days will not invalidate a claim or reduce any benefit payment that may be found to be eligible, if it can be shown that it was provided as soon as reasonably possible. No claim will be denied based upon Your failure to provide notice within such specified time, unless this failure operates to prejudice the right of the Company.

Claim Forms
At the time You provide Us with Notice of Claim, We will assist You with Your Proof of Loss by providing You with instructions and/or forms, which You may have to complete and return to Us. If we do not send the forms within fifteen (15) days after We receive Notice of Claim, You may meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the Occurrence in accordance with the Proof of Loss provision. You are required to cooperate with Us and provide forms and/or documentation as requested by Us which is required and necessary to process Your claim and determine if benefits are payable.

Proof of Loss
Proof of Loss requires You to send Us all the information We request, at Your expense, in order that Your claim may be evaluated and that We may make a determination as to whether the claim may be paid. You must provide Us with satisfactory Proof of Loss within [ninety (90) days] or as soon as reasonably possible, after the date of the Occurrence. Your Proof of Loss documentation may be mailed to Us at the same address provided for mailing Your Notice of Claim. We reserve the right to request all the information We deem necessary to determine that Your claim is payable, and We will not consider that We have received complete Proof of Loss until the information We have requested is received.

Proof of Loss may require documentation consisting of, but not necessarily limited to, the following:

1. a completed claim form;
2. a Police Report or Federal Trade Commission Report;
3. detailed receipts, bills or other records supporting Your claim for covered expenses;
4. a report of a financial institution with respect to fraudulent withdrawals or purchases;
5. the insurance terms for Your other sources of insurance; and
6. written confirmation from the financial institution or credit issuer that they determined the transaction is fraudulent and that no payment was made to You for the Occurrence.

It is Your responsibility to provide all required documentation We request.

Payment of Claim
A claim for benefits provided by this Plan will be paid upon Our receipt and review of Your complete Proof of Loss documentation and Our determination that a claim is payable according to the terms of the Plan.

Any payment made by Us in good faith pursuant to this or any other provision of this Plan will fully discharge Us to the extent of such payment.

TERMINATION OR CANCELLATION

You may terminate Your enrollment at any time by giving Us written or verbal notice in advance of such termination. Notice of termination may be sent to AMEX Assurance Company, Attn: [Business Identity Protection, PO BOX 19020, Green Bay, WI 54307-9020], or by calling [1-800-671-9285]. The effective date of termination will be the date We receive and validate such notice, or a later date as You advise.

Coverage will cease on the earliest of the following:

1. the date We determine You, or anyone acting on Your behalf, committed fraud or intentionally misrepresented information in enrollment or presentation of a claim;
2. the date the Policy or any benefit under the Policy is cancelled. We will provide at least sixty (60) days [for residents of Kentucky seventy-five (75) days] advance written notice to You at Your last known address. The notice will include the reason for cancellation;
3. the date You are no longer a member of a Participating Organization;
4. the date the Participating Organization in which You are a member ceases to participate in the Policy;
5. the date the Plan is not available in the location where You maintain a Permanent Residence;
6. the date You move Your Permanent Residence to a state where the Plan is not available;
7. the date You request termination of insurance;
8. the date We are unable to bill Your premiums due to the status of Your Account. Coverage will continue through the Coverage Period for which premiums have been paid in full; or
9. the date You no longer own a small business.

Cancellation or Termination of this Policy by You or the Company will not prejudice any claim originating prior to that date, subject to all other terms of this Policy.

GENERAL PROVISIONS

Change of Permanent Residence
If the change is to a different state, Your Policy provisions and rates may be adjusted to conform to the requirements of that state. Notification of any such Policy change will be included in the new documents issued to You.

Clerical Error
A clerical error made by the Company will not invalidate insurance otherwise validly in force nor continue insurance not validly in force.

Conformity with State and Federal Law
If a Plan provision does not conform to applicable provisions of State or Federal law, the Plan is hereby amended to comply with such law.

Entire Contract; Representation; Change
This Description of Coverage, the Policy and any application, endorsements or riders make up the entire contract. Any statement You make is a representation and not a warranty. This Description of Coverage may be changed at any time by written agreement between the Master Policyholder and the Company. Only the President, Vice-President or Secretary of the Company may change or waive the provisions of the Description of Coverage. No agent or other person may change the Description of Coverage or waive any of its terms. This Description of Coverage may be changed at any time by providing notice to You. A copy of the Policy will be maintained and kept by the Master Policyholder and may be examined at any time.

Fraud
If any request for benefits made under the Plan is determined to be fraudulent, or if any fraudulent means or devices are used by You or by anyone acting on Your behalf to obtain benefits, all benefits will be denied.

We do not provide coverage to a Covered Person who, whether before or after an Occurrence, has:

1. concealed or misrepresented any fact upon which we rely, if the concealment or misrepresentation is material and is made with the intent to deceive; or
2. concealed or misrepresented any fact if the fact misrepresented contributes to the Occurrence.

Legal Actions
No legal action may be brought to recover against this Plan until [sixty (60)] days after Proof of Loss has been received by Us. No such action may be brought after [three (3)] years (for residents of Arkansas five (5) years, residents of South Dakota six (6) years, and residents of Missouri ten (10) years) from the time written Proof of Loss is required to be given.

[For residents of Alaska, the Legal Actions section is revised to include: If there are any claims, the three (3) year timeframe does not begin to run until after the claim has been denied.]

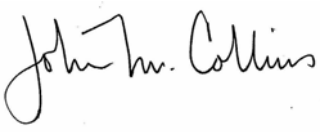
Right of Recovery
If We make a payment to You under this Plan and You recover an amount from another, equal to or less than Our payment, You shall hold in trust for Us the proceeds of the recovery and reimburse Us to the extent of Our payment. If Our payments exceed the maximum amount payable under the benefits of this Plan, We have the right to recover from You any amount exceeding the maximum amount payable.

Subrogation
In the event of any payment under this Policy, We shall be subrogated to the extent of such payment to all Your rights of recovery. You shall execute all papers required and shall do everything necessary to secure and preserve such rights, including the execution of such documents necessary to enable Us to effectively bring suit or otherwise pursue subrogation rights in Your name. You shall do nothing to prejudice such subrogation rights. We shall be entitled to a recovery as stated in these provisions only after You have been fully compensated for damages by another party.

[For residents of Louisiana, the Right of Recovery and Subrogation sections are revised to reflect: If the Company makes any payment under this Policy and the Covered Person has the right to recover damages from another, the Company shall be subrogated to that right. However, the Company's right to recover is subordinate to the Covered Person's right to be fully compensated.]

IN WITNESS WHEREOF, We have caused this Description of Coverage to be signed by Our officers:

[



]

[Joy A. Hanson]
President
AMEX Assurance Company

[John M. Collins]
Secretary
AMEX Assurance Company

Business Identity Protection

Enrollment Request for the Exclusive Use of:

Yes, Please Enroll Me in *Business Identity Protection* under the following coverage plan:
(Select one of the following coverage plans)

☐ $20,000 ($10.99 Monthly)
☐ $20,000 ($126 Annually)
☐ $30,000 ($12.99 Monthly)
☐ $30,000 ($144 Annually)

I request enrollment in *Business Identity Protection*, underwritten by AMEX Assurance Company, under Master Policy AX825. I understand and agree that if I return this form signed and have not checked one of the coverage plans, I will be enrolled in the $20,000 monthly plan.

I have read, understand and agree to the Summary Terms and Conditions of the Policy AX825 explained in this enrollment packet. I understand that coverage is effective when AMEX Assurance Company receives, approves and validates this enrollment request and the first premium is paid. I understand that the premium will be billed to my Account monthly or annually until I notify AMEX Assurance Company to terminate my enrollment.

Please bill my monthly or annual premium to the following American Express Account:

Card number: _____ Expiration _____/_____

X_____ _____/_____/_____
Signature of Enrollee (Please sign in ink) Today's Date

(_____)_____
Telephone Number (required)

Any person who knowingly and with intent to defraud any insurance company, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

Business Identity Protection

Enrollment Request for the Exclusive Use of:

Yes, Please Enroll Me in *Business Identity Protection* under the following coverage plan:
(Select one of the following coverage plans)

- ☐ $20,000 ($10.99 Monthly)
- ☐ $30,000 ($12.99 Monthly)
- ☐ $20,000 ($126 Annually)
- ☐ $30,000 ($144 Annually)

I request enrollment in *Business Identity Protection*, underwritten by AMEX Assurance Company. I understand and agree that if I return this form signed and have not checked one of the coverage plans, I will be enrolled in the $20,000 monthly plan.

I have read, understand and agree to the Summary Terms and Conditions of the Policy explained in this enrollment packet. I understand that coverage is effective when AMEX Assurance Company receives, approves and validates this enrollment request and the first premium is paid. I understand that the premium will be billed to my Account monthly or annually until I notify AMEX Assurance Company to terminate my enrollment.

Please bill my monthly or annual premium to the following American Express Account:

Card number: _____ Expiration _____/_____

X_____ _____/_____/_____
Signature of Enrollee (Please sign in ink) Today's Date

(_____)_____
Telephone Number (required)

Any person who knowingly and with intent to defraud any insurance company, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Uniform Transmittal Document-Property & Casualty	Approved	03/26/2008

Comments:
Please see below.
Attachment:
industry_rates_PCtransDoc_intelligent.pdf

		Review Status:	
Satisfied -Name:	Response Letter	Approved	03/26/2008

Comments:
Please see below.
Attachment:
AR Response Cover Letter 3.25.08.pdf

Effective March 1, 2007

Property & Casualty Transmittal Document

Reset Form

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

3.	Group Name	Group NAIC #

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	AMEX Assurance Company	IL	27928	36-2760101	

5.	Company Tracking Number	

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Michelle Correa 480 Pilgrim Way, Ste 1400 Green Bay, WI 54304	Compliance Analyst	920-431-4020	920-431-4040	michelle.correa@aexp.com

7.	Signature of authorized filer	Michelle Correa Digitally signed by Michelle Correa DN: cn=Michelle Correa, c=US, o=Amex Assurance, ou=Compliance, email=michelle.c.zayas@aexp.com Date: 2008.03.12 11:58:50 -05'00'
8.	Please print name of authorized filer	Michelle Correa

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	09.0 Inland Marine
10.	**Sub-Type of Insurance (Sub-TOI)**	09.0006 Other Personal Inland Marine
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**	
12.	**Company Program Title (**Marketing title)	Identity Protection/Business Identity Protection
13.	**Filing Type**	☐ Rate/Loss Cost ☐ Rules ☐ Rates/Rules ☑ Forms ☐ Combination Rates/Rules/Forms ☐ Withdrawal ☐ Other (give description)
14.	**Effective Date(s) Requested**	New: Upon Approval. Renewal:
15.	**Reference Filing?**	☐ Yes ☑ No
16.	**Reference Organization (**if applicable)	
17.	**Reference Organization # & Title**	
18.	**Company's Date of Filing**	
19.	**Status of filing in domicile**	☐ Not Filed ☑ Pending ☐ Authorized ☐ Disapproved

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	AX825-AR-0001F

21.	**Filing Description** [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Please see Filing Description in the General Information Tab.

View Complete Filing Description

22.	**Filing Fees** (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #: EFT
Amount: 50.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

Effective March 1, 2007

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)

(Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	AX825-AR-0001F
2.	**This filing corresponds to rate/rule filing number** (Company tracking number of rate/rule filing, if applicable)	

3.	**Form Name /Description/Synopsis**	**Form # Include edition date**	**Replacement Or withdrawn?**	**If replacement, give form # it replaces**	**Previous state filing number,** if required by state
01	Description of Coverage	IDP-DOC 03/08	☑ New ☐ Replacement ☐ Withdrawn		
02	Enrollment Request Form	IDP-EN 03/08	☑ New ☐ Replacement ☐ Withdrawn		
03	Enrollment Request Form	IDP-EN-IND 03/08	☑ New ☐ Replacement ☐ Withdrawn		
04	Enrollment Request Form-Multi	IDP-EN-MULTI 03/08	☑ New ☐ Replacement ☐ Withdrawn		
05	Description of Coverage	BIDP-DOC 03/08	☑ New ☐ Replacement ☐ Withdrawn		
06	Enrollment Request Form	BIDP-EN 03/08	☑ New ☐ Replacement ☐ Withdrawn		
07	Enrollment Request Form	BIDP-EN-IND 03/08	☑ New ☐ Replacement ☐ Withdrawn		
08	Enrollment Request Form-Multi	BIDP-EN-MULTI 03/08	☑ New ☐ Replacement ☐ Withdrawn		
09			☐ New ☐ Replacement ☐ Withdrawn		
10			☐ New ☐ Replacement ☐ Withdrawn		

PC FFS-1

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	

2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	

☐ Rate Increase ☐ Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a	**Overall percentage rate indication (when applicable)**		
5b	**Overall percentage rate impact for this filing**		
5c	**Effect of Rate Filing – Written premium change for this program**		
5d	**Effect of Rate Filing – Number of policyholders affected**		

6.	**Overall percentage of last rate revision**	
7.	**Effective Date of last rate revision**	
8.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	

9.	**Rule # or Page # Submitted for Review**	**Replacement or withdrawn?**	**Previous state filing number, if required by state**
01		☐ New ☐ Replacement ☐ Withdrawn	
02		☐ New ☐ Replacement ☐ Withdrawn	
03		☐ New ☐ Replacement ☐ Withdrawn	

March 25, 2008

Arkansas Department of Insurance
Via SERFF
Attn: Becky Harrington

AMEX Assurance Company
480 Pilgrim Way, Suite 1400
Green Bay, WI 54304

RE: FILING SUBMITTED FOR APPROVAL
AMEX Assurance Company
Group Inland Marine Filing – "Identity Protection" and "Business Identity Protection"
Company FEIN: 36-2760101
NAIC #: 27928
Company File Number: AX825-AR-0001

FORMS:

IDP-DOC 03/08	Description of Coverage
IDP-EN 03/08	Enrollment Request Form
IDP-EN-MULTI 03/08	Enrollment Request Form-Multi
BIDP-DOC 03/08	Description of Coverage
BIDP-EN 03/08	Enrollment Request Form
BIDP-EN-MULTI 03/08	Enrollment Request Form-Multi

Dear Ms. Harrington,

We are in receipt of your objection letter dated March 17, 2008 and wish to respond at this time.

1. **Enrollment Request Form, IDP-EN-IND 03/08, Enrollment Request Form-MULTI, IDP-EN-MULTI 03/08. Please explain the difference in these two forms.**

   The Enrollment Request Form, IDP-EN-IND 03/08 is only used for an individual state and since this is a Group Inland Marine Policy it was submitted in error. Please disregard Enrollment Request Form (IDP-EN-IND 03/08).

   We filed the Enrollment Request Form, IDP-EN-MULTI 03/08 to be used for marketing campaigns that are sent out to Cardmembers who are members of participating organizations and who are currently not.

2. **Enrollment Request Form, BIDP-EN-IND 03/08, Enrollment Request Form-MULTI, BIDP-EN-MULTI 03/08. Please explain the difference in these two forms.**

   The Enrollment Request Form, BIDP-EN-IND 03/08 is only used for an individual state and since this is a Group Inland Marine Policy it was submitted in error. Please disregard Enrollment Request Form (BIDP-EN-IND 03/08).

   We filed the Enrollment Request Form, IDP-EN-MULTI 03/08 to be used for marketing campaigns that are sent out to Cardmembers who are members of participating organizations and who are currently not.

This filing has been reviewed and to the best of my knowledge, complies with all applicable Arkansas laws and regulations now in effect.

If you should have any questions, please contact me by phone at 1-888-618-8441, Ext. 4065, by fax at 1-920-431-4040 or by email at Kiley.M.Rickert@aexp.com.

Sincerely,

Kiley Rickert

Kiley Rickert
Senior Compliance Analyst
AMEX Assurance Company

SERFF Tracking Number:	*AMEE-125527044*	*State:*	*Arkansas*
Filing Company:	*AMEX Assurance Company*	*State Tracking Number:*	*EFT $50*
Company Tracking Number:	*AX825-AR-0001F*		
TOI:	*09.0 Inland Marine*	*Sub-TOI:*	*09.0006 Other Personal Inland Marine*
Product Name:	*Identity Protection/Business Identity Protection*		
Project Name/Number:	*IDP/BIDP/AX825-AR-0001F*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Enrollment Request Form	03/10/2008	IDP Enrollment Form. IND 3.6.08.pdf
No original date	Form	Enrollment Request Form	03/10/2008	BIDP Enrollment Form IND 3.6.08.pdf

Identity Protection

Enrollment Request for the Exclusive Use of:

Yes, Please Enroll Me in *Identity Protection* Under the following billing plan:
(select one of the following billing plans)

☐ Monthly Plan at $5.95 per month ☐ Annual Plan at $59.95 per year

I request enrollment in *Identity Protection*, underwritten by AMEX Assurance Company. I understand and agree that if I return this form signed and have not checked one of the billing plans, I will be enrolled in the Monthly Plan.

I have read, understand and agree to the Summary Terms and Conditions of the Policy explained in this enrollment packet. I understand that coverage is effective when AMEX Assurance Company receives, approves and validates this enrollment request and the first premium is paid. I understand that the premium will be billed to my Account monthly or annually until I notify AMEX Assurance Company to terminate my enrollment.

Please bill my monthly or annual premium to the following American Express Account:

Card number _____ Expiration _____/_____

X_____ _____/_____/_____
Signature of Enrollee (Please sign in ink) Today's Date

(_____)_____
Telephone Number (required)

Any person who knowingly and with intent to defraud any insurance company, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.

Business Identity Protection

Enrollment Request for the Exclusive Use of:

Yes, Please Enroll Me in *Business Identity Protection* under the following coverage plan:
(Select one of the following coverage plans)

☐ $20,000 ($10.99 Monthly)
☐ $20,000 ($126 Annually)
☐ $30,000 ($12.99 Monthly)
☐ $30,000 ($144 Annually)

I request enrollment in *Business Identity Protection*, underwritten by AMEX Assurance Company. I understand and agree that if I return this form signed and have not checked one of the coverage plans, I will be enrolled in the $20,000 monthly plan.

I have read, understand and agree to the Summary Terms and Conditions of the Policy explained in this enrollment packet. I understand that coverage is effective when AMEX Assurance Company receives, approves and validates this enrollment request and the first premium is paid. I understand that the premium will be billed to my Account monthly or annually until I notify AMEX Assurance Company to terminate my enrollment.

Please bill my monthly or annual premium to the following American Express Account:

Card number: _____ Expiration _____/_____

X_____ _____/_____/_____
Signature of Enrollee (Please sign in ink) Today's Date

(_____)_____
Telephone Number (required)

Any person who knowingly and with intent to defraud any insurance company, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud.